

		FOR OHF USE					

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**2003**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2003)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0037762</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>	
<b>Facility Name:</b> <u>Albany Care Inc</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/03</u> to <u>12/31/03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
<b>Address:</b> <u>901 Maple</u> <u>Evanston</u> <u>60202</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
<b>County:</b> <u>Cook</u>		<b>Officer or Administrator of Provider</b> (Signed) _____ (Date) _____ (Type or Print Name) _____ (Title) _____	
<b>Telephone Number:</b> <u>(847) 475-4000</u> <b>Fax #</b> <u>(847) 475-8316</u>		<b>Paid Preparer</b> (Signed) _____ (Date) _____ (Print Name and Title) <u>Cary C. Buxbaum, C.P.A.</u> (Firm Name & Address) <u>Frost, Ruttenberg &amp; Rothblatt, P.C.</u> <u>111 Pfingsten Road, Suite 300 Deerfield, IL 60015</u> (Telephone) <u>(847) 236-1111</u> <b>Fax #</b> <u>(847) 236-1155</u>	
<b>IDPA ID Number:</b> <u>363764987001</u>		<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> 201 S. Grand Avenue East Springfield, IL 62763-0001 <b>Phone #</b> (217) 782-1630	
<b>Date of Initial License for Current Owners:</b> <u>11/01/91</u>			
<b>Type of Ownership:</b>			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust <b>IRS Exemption Code</b> _____		<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>Steve Lavenda</u> <b>Telephone Number:</b> <u>(847) 236 - 1111</u>			

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care Inc# 0037762 Report Period Beginning: 01/01/03 Ending: 12/31/03

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed bedsN/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	<u>417</u>	Intermediate (ICF)	<u>417</u>	<u>152,205</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>417</u>	TOTALS	<u>417</u>	<u>152,205</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF					8
9	SNF/PED					9
10	ICF	<u>134,859</u>	<u>1,150</u>	<u>490</u>	<u>136,499</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>134,859</u>	<u>1,150</u>	<u>490</u>	<u>136,499</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 89.68%

D. How many bed-hold days during this year were paid by Public Aid?

2,787 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 11/01/91

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 11/01/91 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number  
of beds certified \_\_\_\_\_ and days of care provided \_\_\_\_\_Medicare Intermediary N/A

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/03 Fiscal Year: 12/31/03

\* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number Albany Care Inc

# 0037762

Report Period Beginning:

01/01/03

Ending:

12/31/03

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	272,131	45,491	64,140	381,762		381,762	(36,913)	344,849			1
2	Food Purchase		422,041		422,041	(14,454)	407,587	(35)	407,552			2
3	Housekeeping	242,241	42,247		284,488		284,488	1,059	285,547			3
4	Laundry		32,491	20,754	53,245		53,245		53,245			4
5	Heat and Other Utilities			330,102	330,102		330,102	3,660	333,762			5
6	Maintenance	73,087	22,898	171,240	267,225		267,225	(47,050)	220,175			6
7	Other (specify):*							8,865	8,865			7
8	<b>TOTAL General Services</b>	587,459	565,168	586,236	1,738,863	(14,454)	1,724,409	(70,414)	1,653,995			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			3,600	3,600		3,600		3,600			9
10	Nursing and Medical Records	2,198,829	41,925	207,078	2,447,832		2,447,832	(47,679)	2,400,153			10
10a	Therapy	20,117	2,640	37,149	59,906		59,906	(15,408)	44,498			10a
11	Activities	372,979	14,157		387,136		387,136		387,136			11
12	Social Services	481,100		649	481,749		481,749		481,749			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*							13,704	13,704			15
16	<b>TOTAL Health Care and Programs</b>	3,073,025	58,722	248,476	3,380,223		3,380,223	(49,383)	3,330,840			16
	<b>C. General Administration</b>											
17	Administrative	152,263		717,658	869,921		869,921	(361,248)	508,673			17
18	Directors Fees											18
19	Professional Services			257,897	257,897	(264)	257,633	(189,388)	68,245			19
20	Dues, Fees, Subscriptions & Promotions			77,646	77,646		77,646	(19,463)	58,183			20
21	Clerical & General Office Expenses	285,875	101,044	97,700	484,619		484,619	2,882	487,501			21
22	Employee Benefits & Payroll Taxes			591,026	591,026	14,454	605,480	(7,236)	598,244			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,177	10,177		10,177	(1,459)	8,718			24
25	Other Admin. Staff Transportation			18,358	18,358		18,358	(394)	17,964			25
26	Insurance-Prop.Liab.Malpractice			327,895	327,895		327,895	2,206	330,101			26
27	Other (specify):*							63,964	63,964			27
28	<b>TOTAL General Administration</b>	438,138	101,044	2,098,357	2,637,539	14,190	2,651,729	(510,137)	2,141,592			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	4,098,622	724,934	2,933,069	7,756,625	(264)	7,756,361	(629,934)	7,126,427			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Albany Care Inc

#0037762

Report Period Beginning:

01/01/03

Ending:

12/31/03

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			153,644	153,644		153,644	438,729	592,373			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			131,631	131,631		131,631	1,014,928	1,146,559			32
33	Real Estate Taxes			437,857	437,857	264	438,121	11,815	449,936			33
34	Rent-Facility & Grounds			1,738,491	1,738,491		1,738,491	(1,738,491)	(0)			34
35	Rent-Equipment & Vehicles			31,519	31,519		31,519	5,263	36,782			35
36	Other (specify):*							19,854	19,854			36
37	<b>TOTAL Ownership</b>			2,493,142	2,493,142	264	2,493,406	(247,903)	2,245,503			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			228,307	228,307		228,307		228,307			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>			228,307	228,307		228,307		228,307			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,098,622	724,934	5,654,518	10,478,074		10,478,074	(877,837)	9,600,237			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Albany Care Inc

# 0037762

Report Period Beginning: 01/01/03

Ending: 12/31/03

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Refer-	OHF USE	
NON-ALLOWABLE EXPENSES		ence	ONLY	
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals				4
5 Telephone, TV & Radio in Resident Rooms	(475)	05		5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation	194,441	30		9
10 Interest and Other Investment Income	(1,186)	32		10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax	(35)	02		13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions	(360)	20		20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt	(3,526)	21		24
25 Fund Raising, Advertising and Promotional	(14,018)	20		25
26 Income Taxes and Illinois Personal				
Property Replacement Tax	(20,000)	21		26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising	(432)	20		28
29 Other-Attach Schedule	(75,529)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ 78,881		\$	30

OHF USE ONLY						
48	49	50	51	52		

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)	(956,718)		34
35 Other- Attach Schedule			35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ (956,718)		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B) )	\$ (877,837)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.			\$		38
39					39
40 Gift and Coffee Shops					40
41 Barber and Beauty Shops					41
42 Laboratory and Radiology					42
43 Prescription Drugs					43
44 Exceptional Care Program					44
45 Other-Attach Schedule					45
46 Other-Attach Schedule					46
47 TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Albany Care Inc

0037762

Report Period Beginning: 01/01/03

Ending: 12/31/03

Sch. V Line

NON-ALLOWABLE EXPENSES			Amount	Reference
1	Rental Income		\$ (400)	21 1
2	Prescription Drugs-VA		(1,084)	10 2
3	Purchased Services-VA		(423)	10 3
4	Jury Duty Income		(103)	10 4
5	Capitalized Repairs & Maintenance		(16,212)	00 5
6	Directors Fees - Norman Mathews		(30,000)	17 6
7	NAMI Conference Advertising		(33)	20 7
8	IL LTC (COPE)		(8,114)	20 8
9	Nonallowable Legal Fees		(19,663)	19 9
10	Prior Year Expense		(417)	31 10
11				31
12				32
13				33
14				34
15				35
16				36
17				37
18				38
19				39
20				40
21				41
22				42
23				43
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93				113
94				114
95				115
96				116
97				117
98				118
99				119
100				120
101	Total		(75,529)	101

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Albany Care Inc

# 0037762

Report Period Beginning:

01/01/03

Ending:

12/31/03

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary					(36,913)							(36,913)	1
2	Food Purchase	(35)											(35)	2
3	Housekeeping			1,059									1,059	3
4	Laundry													4
5	Heat and Other Utilities	(475)		1,366	2,769								3,660	5
6	Maintenance	(16,212)		1,078	(29,758)	(2,158)							(47,050)	6
7	Other (specify):*				2,064	6,801							8,865	7
8	<b>TOTAL General Services</b>	(16,722)		3,503	(24,925)	(32,270)							(70,414)	8
	<b>B. Health Care and Programs</b>													
9	Medical Director													9
10	Nursing and Medical Records	(3,684)			(39,782)			(4,214)					(47,679)	10
10a	Therapy					(15,408)							(15,408)	10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*				9,104	4,600							13,704	15
16	<b>TOTAL Health Care and Programs</b>	(3,684)			(30,678)	(10,808)		(4,214)					(49,383)	16
	<b>C. General Administration</b>													
17	Administrative	(30,000)		26,245	(34,170)	(323,323)							(361,248)	17
18	Directors Fees													18
19	Professional Services	(19,663)		(155,254)	(33,280)	18,809							(189,388)	19
20	Fees, Subscriptions & Promotions	(19,956)	25	304	164								(19,463)	20
21	Clerical & General Office Expenses	(24,349)	3,542	86,689	(63,000)								2,882	21
22	Employee Benefits & Payroll Taxes				(6,600)		(614)		(22)				(7,236)	22
23	Inservice Training & Education													23
24	Travel and Seminar			256	(1,715)								(1,459)	24
25	Other Admin. Staff Transportation			1,191	(1,585)								(394)	25
26	Insurance-Prop.Liab.Malpractice			602	1,604								2,206	26
27	Other (specify):*			15,426	6,856	41,682							63,964	27
28	<b>TOTAL General Administration</b>	(93,968)	3,567	(24,541)	(131,726)	(262,832)	(614)		(22)				(510,137)	28
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	(114,374)	3,567	(21,038)	(187,329)	(305,910)	(614)	(4,214)	(22)				(629,934)	29

## STATE OF ILLINOIS

Summary B

Facility Name & ID Number Albany Care Inc# 0037762

Report Period Beginning:

01/01/03

Ending:

12/31/03

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>D. Ownership</b>													
30	Depreciation	194,441	234,183	3,804	6,301								438,729	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(1,186)	1,009,509	1,037	5,568								1,014,928	32
33	Real Estate Taxes			3,501	8,314								11,815	33
34	Rent-Facility & Grounds		(1,738,491)										(1,738,491)	34
35	Rent-Equipment & Vehicles			3,429	1,834								5,263	35
36	Other (specify):*		19,854										19,854	36
37	<b>TOTAL Ownership</b>	193,255	(474,946)	11,771	22,017								(247,903)	37
	<b>Ancillary Expense</b>													
	<b>E. Special Cost Centers</b>													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	<b>TOTAL Special Cost Centers</b>													44
	<b>GRAND TOTAL COST</b>													
45	(sum of lines 29, 37 & 44)	78,881	(471,379)	(9,267)	(165,312)	(305,910)	(614)	(4,214)	(22)				(877,837)	45

Facility Name & ID Number Albany Care Inc# 0037762

Report Period Beginning:

01/01/03

Ending:

12/31/03

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent	\$ 1,738,491	Albany Care, LLC		\$	(1,738,491)	1
2	V	36 Amortization				19,854	19,854	2
3	V	30 Depreciation				234,183	234,183	3
4	V	20 Filing Fees				25	25	4
5	V	32 Mortgage Interest				1,009,573	1,009,573	5
6	V	33 Real Estate Taxes						6
7	V	32 Interest Income	64				(64)	7
8	V	21 Replacement Tax				3,542	3,542	8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 1,738,556			\$ 1,267,177	\$ * (471,379)	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care Inc# 0037762Report Period Beginning: 01/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	3 HOUSEKEEPING	\$	PREFERRED BOOKKEEPING	100.00%	\$ 1,059	\$ 1,059
16	V	5 UTILITIES		PREFERRED BOOKKEEPING	100.00%	1,366	1,366
17	V	6 REPAIRS AND MAINT.		PREFERRED BOOKKEEPING	100.00%	1,078	1,078
18	V	17 ADMIN. FINANCIAL SAL.		PREFERRED BOOKKEEPING	100.00%	26,245	26,245
19	V	19 PROFESSIONAL FEES		PREFERRED BOOKKEEPING	100.00%	3,350	3,350
20	V	20 DUES,SUBSCRIPTIONS		PREFERRED BOOKKEEPING	100.00%	304	304
21	V	21 CLERICAL		PREFERRED BOOKKEEPING	100.00%	86,689	86,689
22	V	24 SEMINARS		PREFERRED BOOKKEEPING	100.00%	256	256
23	V	25 ADMIN. STAFF TRAVEL		PREFERRED BOOKKEEPING	100.00%	1,191	1,191
24	V	26 INSURANCE		PREFERRED BOOKKEEPING	100.00%	602	602
25	V	27 EMPLOYEE BENEFITS		PREFERRED BOOKKEEPING	100.00%	15,426	15,426
26	V	30 DEPRECIATION		PREFERRED BOOKKEEPING	100.00%	3,804	3,804
27	V	32 INTEREST		PREFERRED BOOKKEEPING	100.00%	1,037	1,037
28	V	33 REAL ESTATE TAXES		PREFERRED BOOKKEEPING	100.00%	3,501	3,501
29	V	35 EQUIPMENT RENTAL		PREFERRED BOOKKEEPING	100.00%	3,429	3,429
30	V						
31	V						
32	V	19 ACCOUNT./BOOKKEEPING	158,604	PREFERRED BOOKKEEPING	100.00%		(158,604)
33	V	19 COMPUTER	10,008	PREFERRED BOOKKEEPING	100.00%	10,008	
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 168,612			\$ 159,345	\$ * (9,267)

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care Inc# 0037762Report Period Beginning: 01/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	5 UTILITIES	\$	S.I.R. MANAGEMENT, INC.	100.00%	\$ 2,769	\$ 2,769 15
16	V	6 REPAIRS AND MAINT.	37,536	S.I.R. MANAGEMENT, INC.	100.00%	13,178	(24,358) 16
17	V	7 EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	2,064	2,064 17
18	V	10 NURSING	82,572	S.I.R. MANAGEMENT, INC.	100.00%	42,790	(39,782) 18
19	V	15 EMP. BEN.-H.C.		S.I.R. MANAGEMENT, INC.	100.00%	9,104	9,104 19
20	V	17 ADMINISTRATIVE	52,548	S.I.R. MANAGEMENT, INC.	100.00%	18,378	(34,170) 20
21	V	19 PROFESSIONAL FEES	33,780	S.I.R. MANAGEMENT, INC.	100.00%	500	(33,280) 21
22	V	20 FEES,SUBSCRIPTIONS		S.I.R. MANAGEMENT, INC.	100.00%	164	164 22
23	V	21 CLERICAL & GENERAL	42,540	S.I.R. MANAGEMENT, INC.	100.00%	45,732	3,192 23
24	V	24 EDUCATION & SEMINAR		S.I.R. MANAGEMENT, INC.	100.00%	685	685 24
25	V	25 OTHER ADMIN. STAFF TRANS.		S.I.R. MANAGEMENT, INC.	100.00%	4,415	4,415 25
26	V	26 INSURANCE		S.I.R. MANAGEMENT, INC.	100.00%	1,604	1,604 26
27	V	27 EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	6,856	6,856 27
28	V	30 DEPRECIATION		S.I.R. MANAGEMENT, INC.	100.00%	6,301	6,301 28
29	V	32 INTEREST		S.I.R. MANAGEMENT, INC.	100.00%	5,568	5,568 29
30	V	33 REAL ESTATE TAXES		S.I.R. MANAGEMENT, INC.	100.00%	8,314	8,314 30
31	V	35 EQUIPMENT RENTAL		S.I.R. MANAGEMENT, INC.	100.00%	9,034	9,034 31
32	V	21 TELEPHONE & OFFICE	66,192	S.I.R. MANAGEMENT, INC.	100.00%		(66,192) 32
33	V	6 REPAIRS	5,400	S.I.R. MANAGEMENT, INC.	100.00%		(5,400) 33
34	V	35 EQUIPMENT RENTAL	3,000	S.I.R. MANAGEMENT, INC.	100.00%		(3,000) 34
35	V	35 AUTO LEASE	4,200	S.I.R. MANAGEMENT, INC.	100.00%		(4,200) 35
36	V	25 TRAVEL	6,000	S.I.R. MANAGEMENT, INC.	100.00%		(6,000) 36
37	V	24 SEMINARS	2,400	S.I.R. MANAGEMENT, INC.	100.00%		(2,400) 37
38	V	22 EMPLOYEE BENEFITS	6,600	S.I.R. MANAGEMENT, INC.	100.00%		(6,600) 38
39	Total		\$ 342,768			\$ 177,456	\$ * (165,312) 39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Albany Care Inc

# 0037762

Report Period Beginning: 01/01/03

Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3	4	5	6	7	8
Schedule V	Line	Cost Per General Ledger	Amount	Cost to Related Organization	Percent of Ownership	Operating Cost of Related Organization	Difference: Adjustments for Related Organization Costs (7 minus 4)
15	V	1	DIETARY SALARIES	\$ 42,540	S.I.R. MANAGEMENT, INC.	100.00%	\$ 13,496
16	V	7	EMP. BEN.-DIETARY		S.I.R. MANAGEMENT, INC.	100.00%	2,871
17	V	17	ADMIN/LEGAL SALARIES	559,510	S.I.R. MANAGEMENT, INC.	100.00%	111,235
18	V	19	FINANCIAL CONSULTANT		S.I.R. MANAGEMENT, INC.	100.00%	28,817
19	V	27	EMP. BEN.-ADMINISTRATIVE		S.I.R. MANAGEMENT, INC.	100.00%	16,735
20	V						
21	V	17	ADMIN. SALARY		S.I.R. MANAGEMENT, INC.	100.00%	74,453
22	V	27	EMP. BEN.-ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	12,614
23	V						
24	V	17	ADMIN SALARY		S.I.R. MANAGEMENT, INC.	100.00%	66,099
25	V	27	EMP. BEN.-ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	12,333
26	V						
27	V	10A	SPECIAL REHAB	37,032	S.I.R. MANAGEMENT, INC.	100.00%	21,624
28	V	15	EMP. BEN.-HEALTH CARE & PROG.		S.I.R. MANAGEMENT, INC.	100.00%	4,600
29	V						
30	V	6	REPAIRS AND MAINT.	6,840	S.I.R. MANAGEMENT, INC.	100.00%	4,682
31	V	7	EMP. BEN.-GEN. SERV.		S.I.R. MANAGEMENT, INC.	100.00%	996
32	V						
33	V	1	DIETICIAN SALARIES	21,600	S.I.R. MANAGEMENT, INC.	100.00%	13,731
34	V	7	EMP. BEN.-GEN. ADMIN.		S.I.R. MANAGEMENT, INC.	100.00%	2,934
35	V						
36	V	19	LEGAL FEES	10,008	S.I.R. MANAGEMENT, INC.	100.00%	
37	V						
38	V	17	COUNCIL DUES	15,600	S.I.R. MANAGEMENT, INC.	100.00%	
39	Total		\$ 693,130			\$ 387,220	\$ * (305,910)

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care Inc# 0037762Report Period Beginning: 01/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 EMPLOYEE HEALTH INSURANCE	\$	CCS EMPLOYEE BENEFIT GROUP	100.00%	\$ 145,612	\$ 145,612	15
16	V							16
17	V							17
18	V							18
19	V	22 EMPLOYEE HEALTH INSURANCE	146,226	CCS EMPLOYEE BENEFIT GROUP	100.00%		(146,226)	19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 146,226			\$ 145,612	\$ * (614)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Albany Care Inc

# 0037762

Report Period Beginning: 01/01/03

Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	01 DIETARY	\$	XCEL MEDICAL SUPPLY, LLC	100.00%	\$	\$	15
16	V	02 FOOD		XCEL MEDICAL SUPPLY, LLC	100.00%			16
17	V	03 HOUSEKEEPING		XCEL MEDICAL SUPPLY, LLC	100.00%			17
18	V	04 LAUNDRY		XCEL MEDICAL SUPPLY, LLC	100.00%			18
19	V	06 REPAIRS & MAINTENANCE		XCEL MEDICAL SUPPLY, LLC	100.00%			19
20	V	10 NURSING	32,013	XCEL MEDICAL SUPPLY, LLC	100.00%	27,799	(4,214)	20
21	V	10A THERAPY		XCEL MEDICAL SUPPLY, LLC	100.00%			21
22	V	12 SOCIAL SERVICE		XCEL MEDICAL SUPPLY, LLC	100.00%			22
23	V	21 CLERICAL & GENERAL OFFICE		XCEL MEDICAL SUPPLY, LLC	100.00%			23
24	V	22 EMPLOYEE BENEFITS		XCEL MEDICAL SUPPLY, LLC	100.00%			24
25	V	39 ANCILLARY		XCEL MEDICAL SUPPLY, LLC	100.00%			25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 32,013			\$ 27,799	\$ * (4,214)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care Inc# 0037762Report Period Beginning: 01/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	22 HEALTH INSURANCE	\$ 18,320	ECM OWNERS COUNCIL	100.00%	\$ 18,480	\$ 160	15
16	V	17 ADMINISTRATOR SALARY	4,800	ECM OWNERS COUNCIL	100.00%	4,800		16
17	V	22 PAYROLL TAXES	600	ECM OWNERS COUNCIL	100.00%	418	(182)	17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 23,720			\$ 23,698	\$ * (22)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care Inc# 0037762Report Period Beginning: 01/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care Inc# 0037762Report Period Beginning: 01/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care Inc# 0037762Report Period Beginning: 01/01/03Ending: 12/31/03

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V		\$			\$	\$	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$	\$ *	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

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Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/03 Ending: 12/31/03

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Louise Bergthold	Shareholder	Administrative	0.72%	See Attached	11.70	21.27%	Alloc Sal	\$ 37,917	17-7	1
2	Patricia McDiarmid	Shareholder	Administrative	0.48%	See Attached	10.64	21.28%	Alloc Sal	18,378	17-7	2
3	Jeff Oravec	Shareholder	Administrative	0.48%	See Attached	8.51	21.28%	Alloc Sal	19,261	17-7,21-7	3
4	Thomas Winter	Shareholder	Administrative	0.72%	See Attached	10.17	16.95%	Alloc Sal/Mgt	56,245	17-7,17-3	4
5	Bryan Barrish	Shareholder	Administrative	4.98%	See Attached	13.10	32.75%	Alloc Sal	74,453	17-7	5
6	Mike Gianni	Shareholder	Administrative	4.98%	See Attached	13.10	32.75%	Alloc Sal	66,099	17-7	6
7	Nenita Guzman	Relative	Dietary	0	See Attached	10.64	21.28%	Alloc Sal	13,496	1-7	7
8	Eric Rothner	Shareholder	Administrative	4.56%	See Attached	1.17	2.13%	Alloc Sal	60,689	17-7	8
9	Dennis Tossi	Shareholder	Administrator	3.12%	None	40.00	100.00%	Salary	113,889	17-1	9
10	Adam Vales	Relative	Clerical	0	See Attached	0.75	1.88%	Alloc Sal	583	22-7	10
11											11
12											12
13								TOTAL	\$ 461,010		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/03 Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care Inc# 0037762

Report Period Beginning:

01/01/03Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization PREFERRED BOOKKEEPING SERVICES  
 Street Address 4100 WEST PRATT AVE.  
 City / State / Zip Code LINCOLNWOOD, IL. 60712  
 Phone Number ( 847) 674-5200  
 Fax Number ( 847) 674-5267

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	HOUSEKEEPING	BOOK./ACCNT.INCOME	935,658	11	\$ 6,250	\$ 158,604	\$ 1,059	1
2	5	UTILITIES	BOOK./ACCNT.INCOME	935,658	11	8,058	158,604	1,366	2
3	6	REPAIRS AND MAINT.	BOOK./ACCNT.INCOME	935,658	11	6,361	158,604	1,078	3
4	17	ADMIN. FINANCIAL SAL.	BOOK./ACCNT.INCOME	935,658	11	154,828	158,604	26,245	4
5	19	PROFESSIONAL FEES	BOOK./ACCNT.INCOME	935,658	11	19,761	158,604	3,350	5
6	20	DUES,SUBSCRIPTIONS	BOOK./ACCNT.INCOME	935,658	11	1,793	158,604	304	6
7	21	CLERICAL	BOOK./ACCNT.INCOME	935,658	11	511,408	453,848	86,689	7
8	24	SEMINARS	BOOK./ACCNT.INCOME	935,658	11	1,508	158,604	256	8
9	25	ADMIN. STAFF TRAVEL	BOOK./ACCNT.INCOME	935,658	11	7,028	158,604	1,191	9
10	26	INSURANCE	BOOK./ACCNT.INCOME	935,658	11	3,553	158,604	602	10
11	27	EMPLOYEE BENEFITS	BOOK./ACCNT.INCOME	935,658	11	91,005	158,604	15,426	11
12	30	DEPRECIATION	BOOK./ACCNT.INCOME	935,658	11	22,443	158,604	3,804	12
13	32	INTEREST	BOOK./ACCNT.INCOME	935,658	11	6,117	158,604	1,037	13
14	33	REAL ESTATE TAXES	BOOK./ACCNT.INCOME	935,658	11	20,656	158,604	3,501	14
15	35	EQUIPMENT RENTAL	BOOK./ACCNT.INCOME	935,658	11	20,229	158,604	3,429	15
16									16
17									17
18									18
19	19	COMPUTER	DIRECT ALLOCATION					10,008	19
20									20
21									21
22									22
23									23
24									24
25	TOTALS					\$ 880,998	\$ 608,675	\$ 159,345	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care Inc# 0037762

Report Period Beginning:

01/01/03Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization S.I.R. MANAGEMENT, INC.Street Address 6840 N. LINCOLNCity / State / Zip Code LINCOLNWOOD, IL. 60712Phone Number ( 847) 675 -7979Fax Number ( 847) 675 -0555

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5 UTILITIES	PATIENT DAYS	641,706	10	\$ 13,016	\$	136,499	\$ 2,769	1
2	6 REPAIRS AND MAINT.	PATIENT DAYS	641,706	10	61,951		136,499	13,178	2
3	7 EMP. BEN.-GEN. SERV.	PATIENT DAYS	641,706	10	9,705		136,499	2,064	3
4	10 NURSING	PATIENT DAYS	641,706	10	201,162	201,162	136,499	42,790	4
5	15 EMP. BEN.-H.C.	PATIENT DAYS	641,706	10	42,801		136,499	9,104	5
6	17 ADMINISTRATIVE	PATIENT DAYS	641,706	10	86,401	86,401	136,499	18,378	6
7	19 PROFESSIONAL FEES	PATIENT DAYS	641,706	10	2,349		136,499	500	7
8	20 FEES,SUBSCRIPTIONS	PATIENT DAYS	641,706	10	773		136,499	164	8
9	21 CLERICAL & GENERAL	PATIENT DAYS	641,706	10	214,995	167,138	136,499	45,732	9
10	24 EDUCATION & SEMINAR	PATIENT DAYS	641,706	10	3,219		136,499	685	10
11	25 OTHER ADMIN. STAFF TRANS	PATIENT DAYS	641,706	10	20,755		136,499	4,415	11
12	26 INSURANCE	PATIENT DAYS	641,706	10	7,541		136,499	1,604	12
13	27 EMP. BEN.-GEN. ADMIN.	PATIENT DAYS	641,706	10	32,233		136,499	6,856	13
14	30 DEPRECIATION	PATIENT DAYS	641,706	10	29,623		136,499	6,301	14
15	32 INTEREST	PATIENT DAYS	641,706	10	26,178		136,499	5,568	15
16	33 REAL ESTATE TAXES	PATIENT DAYS	641,706	10	39,087		136,499	8,314	16
17	35 EQUIPMENT RENTAL	PATIENT DAYS	641,706	10	42,473		136,499	9,034	17
18									18
19	35 LEASED EQUIPMENT	LEASING INCOME	24,090	1					19
20	30 DEPRECIATION	LEASING INCOME	24,090	1	91,098				20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 925,360	\$ 500,323		\$ 177,456	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/03 Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization S.I.R. MANAGEMENT, INC.  
 Street Address 6840 N. LINCOLN  
 City / State / Zip Code LINCOLNWOOD, IL. 60712  
 Phone Number ( 847) 675 -7979  
 Fax Number ( 847) 675 -0555

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	DIETARY SALARIES	PATIENT DAYS	641,706	10	\$ 63,448	\$ 63,448	136,499	\$ 13,496	1
2	EMP. BEN.-DIETARY	PATIENT DAYS	641,706	10	13,496		136,499	2,871	2
3	ADMIN./LEGAL SALARIES	PATIENT DAYS	641,706	10	522,936	522,936	136,499	111,235	3
4	FINANCIAL CONSULTANT	PATIENT DAYS	641,706	10	135,472		136,499	28,817	4
5	EMP. BEN.-ADMINISTRATIVE	PATIENT DAYS	641,706	10	\$ 78,674	\$	136,499	\$ 16,735	5
6									6
7	17 ADMIN. SALARY	AVG HRS WKD	30	4	170,502	170,502	13	74,453	7
8	27 EMP. BEN.-ADMIN.	AVG HRS WKD	30	4	28,886		13	12,614	8
9					\$	\$		\$	9
10	17 ADMIN SALARY	AVG HRS WKD	30	4	151,372	151,372	13	66,099	10
11	27 EMP. BEN.-ADMIN.	AVG HRS WKD	30	4	28,244		13	12,333	11
12									12
13	10A SPECIAL REHAB	SPECIAL REHAB INC.	107,736	7	\$ 62,910	\$ 62,910	37,032	\$ 21,624	13
14	15 EMP. BEN.-HEALTH CARE & P	SPECIAL REHAB INC.	107,736	7	13,382		37,032	4,600	14
15									15
16	6 REPAIRS AND MAINT.	MAINTENANCE INC.	163,332	10	111,809	111,809	6,840	4,682	16
17	7 EMP. BEN.-GEN. SERV.	MAINTENANCE INC.	163,332	10	23,783		6,840	996	17
18									18
19	1 DIETICIAN SALARIES	DIETICIAN SERVICE INC.	125,400	10	79,717	79,717	21,600	13,731	19
20	7 EMP. BEN.-GEN. ADMIN.	DIETICIAN SERVICE INC.	125,400	10	17,031		21,600	2,934	20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 1,501,663	\$ 1,162,695		\$ 387,220	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/03 Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization CCS EMPLOYEE BENEFITS GROUP, INC.  
 Street Address 2201 WEST MAIN STREET  
 City / State / Zip Code EVANSTON, IL 60202  
 Phone Number ( 847)905-4000  
 Fax Number ( 847)905-4040

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22	EMPLOYEE HEALTH INSURANCE	DIRECT ALLOCATION		\$	\$		\$ 145,612	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 145,612	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/03 Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization XCEL MEDICAL SUPPLY, LLC  
 Street Address 2201 MAIN STREET  
 City / State / Zip Code EVANSTON, IL 60202  
 Phone Number ( 847)328-7600  
 Fax Number ( 847)328-7615

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	01	DIETARY	DIRECT ALLOCATION		\$	\$		\$	1
2	02	FOOD	DIRECT ALLOCATION						2
3	03	HOUSEKEEPING	DIRECT ALLOCATION						3
4	04	LAUNDRY	DIRECT ALLOCATION						4
5	06	REPAIRS & MAINTENANCE	DIRECT ALLOCATION						5
6	10	NURSING	DIRECT ALLOCATION					27,799	6
7	10A	THERAPY	DIRECT ALLOCATION						7
8	12	SOCIAL SERVICE	DIRECT ALLOCATION						8
9	21	CLERICAL & GENERAL OFFICE	DIRECT ALLOCATION						9
10	22	EMPLOYEE BENEFITS	DIRECT ALLOCATION						10
11	39	ANCILLARY	DIRECT ALLOCATION						11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 27,799	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/03 Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization ECM OWNERS COUNCIL  
 Street Address 6840 N. LINCOLN  
 City / State / Zip Code LINCOLNWOOD, IL 60646  
 Phone Number ( 847)676-2026  
 Fax Number ( )

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	22 HEALTH INSURANCE	DIRECT ALLOCATION		4	\$	\$		\$ 18,480	1
2	17 ADMINISTRATOR SALARY	DIRECT ALLOCATION		4				4,800	2
3	22 PAYROLL TAXES	DIRECT ALLOCATION		4				418	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$ 23,698	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/03 Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/03 Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care Inc # 0037762 Report Period Beginning: 01/01/03 Ending: 12/31/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Nomura		X	Mortgage	\$103,874.00	11/20/95	\$ 12,500,000	\$ 11,098,207	12/01/20	8.88%	\$ 1,009,573	1	
2												2	
3												3	
4												4	
5	See Supplemental Schedule											5	
	Working Capital												
6	CIB Bank		X	Improvements				819,469		prime +1%	62,626	6	
7	CIB Bank		X	Working Capital		06/20/03		850,000	08/20/04	prime -.5%	69,005	7	
8	See Supplemental Schedule										6,605	8	
9	TOTAL Facility Related				\$103,874.00		\$ 12,500,000	\$ 12,767,676			\$ 1,147,809	9	
	B. Non-Facility Related*												
10												10	
11	Interest Income		X								(1,250)	11	
12												12	
13	See Supplemental Schedule											13	
14	TOTAL Non-Facility Related						\$	\$			\$ (1,250)	14	
15	TOTALS (line 9+line14)						\$ 12,500,000	\$ 12,767,676			\$ 1,146,559	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 0 Line # N/A

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE - SUPPLEMENTAL SCHEDULE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1							\$	\$			\$	1							
2												2							
3												3							
4												4							
5												5							
6												6							
7	TOTAL Long-Term											7							
	Working Capital																		
8	Alloc Pref Bookkeeping		X				\$	\$			\$ 1,037	8							
9	Alloc S.I.R. Management		X								5,568	9							
10												10							
11												11							
12												12							
13												13							
14	TOTAL Working Capital										6,605	14							
	B. Non-Facility Related*																		
15							\$	\$			\$	15							
16												16							
17												17							
18												18							
19												19							
20	TOTAL Non-Facility Related											20							

- \* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT
- \*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

1. Real Estate Tax accrual used on 2002 report.		<div style="border: 1px solid black; padding: 2px; display: inline-block;"> <b>Important</b>, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.         </div>		\$	434,400	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		\$	442,472	2		
3. Under or (over) accrual (line 2 minus line 1).		\$	8,072	3		
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)		\$	441,600	4		
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		\$	264	5		
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund.						
<b>TOTAL REFUND</b> \$ _____ <b>For</b> _____ <b>Tax Year.</b> (Attach a copy of the real estate tax appeal board's decision.)		\$		6		
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		\$	449,936	7		

  

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1998	1999	2000	2001	2002
	439,710	449,196	457,691	423,570	430,657
	8	9	10	11	12

Alloc S.I.R. Mgt=7,305.25

Alloc Preferred=3,076.37

Accrual =430,657 x 1.025 = 441,600 rounded

FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	\$
14	PLUS APPEAL COST FROM LINE 5	\$
15	LESS REFUND FROM LINE 6	\$
16	AMOUNT TO USE FOR RATE CALCULATION	\$

1. Please indicate a negative number by use of brackets ( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**SEE ACCOUNTANTS' COMPILATION REPORT**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2002 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Albany Care Inc COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0037762

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>11-19-121-019-0000</u>	<u>Long Term Care Property</u>	\$ <u>430,656.96</u>	\$ <u>430,656.96</u>
2. <u>See Attached</u>	<u>S.I.R. Management Allocation</u>	\$ <u>74,287.87</u>	\$ <u>10,381.62</u>
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>504,944.83</u></u>	\$ <u><u>441,038.58</u></u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?   X   YES        NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2002 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Albany Care Inc COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0037762

CONTACT PERSON REGARDING THIS REPORT : Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
2.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
3.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
4.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
5.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
6.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
7.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
8.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
9.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
10.	<u>                    </u>	<u>                    </u>	\$ <u>                    </u>	\$ <u>                    </u>
		<b>TOTALS</b>	\$ <u>                    </u>	\$ <u>                    </u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?            YES            NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.  
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

A. Square Feet: 211,753

B. General Construction Type: Exterior Brick Frame \_\_\_\_\_ Number of Stories 7

C. Does the Operating Entity? ☐ (a) Own the Facility ☒ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☒ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.  
 (Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).  
  
None  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO  
 If so, please complete the following:

1. Total Amount Incurred: \_\_\_\_\_ 2. Number of Years Over Which it is Being Amortized: \_\_\_\_\_  
 3. Current Period Amortization: \_\_\_\_\_ 4. Dates Incurred: \_\_\_\_\_

Nature of Costs: \_\_\_\_\_  
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	<u>Facility</u>	<u>24,573</u>	<u>1991</u>	<u>\$ 84,558</u>	1
2					2
3	TOTALS	<u>24,573</u>		<u>\$ 84,558</u>	3

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4				\$	\$		\$	\$	\$
5									
6									
7									
8									
<b>Improvement Type**</b>									
9	Various	1993		61,428		20	3,071	3,071	31,844
10	Various	1994		120,534		20	6,026	6,026	56,436
11	Various	1995		291,499		20	14,331	14,331	121,286
12	Various	1996		58,666		20	2,934	(2,934)	22,059
13	Various	1997		72,445		20	3,740	3,740	23,402
14	Various	1998		177,216		20	8,861	8,861	50,579
15	Various	1999		262,434		20	13,123	13,123	55,928
16							-		-
17							-		-
18							-		-
19							-		-
20							-		-
21							-		-
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28							-		-
29							-		-
30							-		-
31							-		-
32							-		-
33							-		-
34							-		-
35							-		-
36							-		-

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
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60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12-BLDG & 12A-BLDG)		7,267,981	230,730		363,399	132,669	4,421,354	67
68	Related Party Allocations (Pages 12-REP & 12A-REP)		218,013	8,950		9,715	765	96,952	68
69	Financial Statement Depreciation			61,936			(61,936)		69
70	TOTAL (lines 4 thru 69)		\$ 8,530,216	\$ 301,616		\$ 425,200	\$ 117,716	\$ 4,879,840	70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 8,530,216	\$ 301,616		\$ 425,200	\$ 123,584	\$ 4,879,840	1
2	Nurse Call System	2000	5,611		20	281	281	1,123	2
3	Elevator Work	2000	3,750		20	188	188	751	3
4	Elevator Work	2000	3,650		20	183	183	731	4
5	Hvac Work	2000	4,344		20	217	217	741	5
6	Flooring	2000	2,110		20	106	106	414	6
7	Roofing	2000	129,494		20	6,475	6,475	21,043	7
8	Light Fixtures	2000	7,404		20	740	740	2,283	8
9	Dining Room Floor	2000	55,275		20	2,764	2,764	8,522	9
10	Painting	2000	16,595		20	830	830	2,559	10
11	Kitchen Compressor	2000	2,307		20	115	115	404	11
12	Ceiling Tiles	2000	3,111		20	156	156	467	12
13	Thermostat	2000	1,585		20	79	79	238	13
14	Overhead Garage	2000	850		20	43	43	128	14
15	Heat Pump	2000	1,398		20	70	70	210	15
16	Door Alarm	2000	1,098		20	55	55	165	16
17	Compressor	2000	1,122		20	56	56	168	17
18	Tile Flooring	2001	59,176		20	5,918	5,918	12,821	18
19	Tile Flooring	2001	2,887		20	289	289	626	19
20	Tile Flooring	2001	8,059		20	806	806	1,746	20
21	Electrical Work	2001	6,335		20	317	317	951	21
22	Lighting	2001	3,530		20	177	177	530	22
23	Hvac Work	2001	8,188		20	409	409	1,160	23
24	Hvac Work	2001	7,275		20	364	364	1,031	24
25	Boiler	2001	206,552		20	10,328	10,328	27,540	25
26	Elevator Work	2001	14,500		20	725	725	1,692	26
27	Bathroom Hvac	2001	4,394		20	220	220	476	27
28	Shower Renovation	2001	39,492		20	1,975	1,975	4,443	28
29	Overhead Garage	2001	1,735		20	87	87	218	29
30	Sewer Work	2001	1,725		20	86	86	216	30
31	Boiler Work	2001	2,967		20	148	148	346	31
32	Staircase	2001	2,860		20	143	143	417	32
33	Shower Renovation	2001			20				33
34	TOTAL (lines 1 thru 33)		\$ 9,139,595	\$ 301,616		\$ 459,550	\$ 157,934	\$ 4,974,000	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 9,139,595	\$ 301,616		\$ 459,550	\$ 157,934	\$ 4,974,000	1
2	Bathroom/Elect Work	2001			20				2
3	Tile Flooring	2001	68,106		20	3,405	3,405	7,379	3
4	Bathroom Work	2001	3,222		20	161	161	483	4
5	Ceiling Light	2002	2,905		20	581	581	1,162	5
6	Flooring - Tile	2002	39,612		20	1,016	1,016	1,947	6
7	Carpeting	2002	163,275		20	4,187	4,187	7,326	7
8	Floor Patching	2002	22,740		20	583	583	1,020	8
9	Painting	2002	310,434		20	7,960	7,960	13,598	9
10	Lobby Remodeling	2002	41,277		20	1,058	1,058	1,102	10
11	Nurse Call	2002	4,756		20	122	122	239	11
12	Nurse Station	2002	78,247		20	2,006	2,006	3,595	12
13	Water Booster	2002	13,387		20	343	343	443	13
14	Water Pump Temp	2002	15,952		20	409	409	460	14
15	Elevator Work	2002	1,844		20	47	47	57	15
16	Handrail	2002	61,523		20	1,578	1,578	2,563	16
17	Window Treatments	2002	87,580		20	2,246	2,246	3,649	17
18	Exhaust Fan	2002	5,257		20	526	526	1,008	18
19	Interior Doors	2002	21,987		20	2,199	2,199	4,214	19
20	Bathroom Partitions	2002	2,888		20	289	289	554	20
21	Door Hinges	2002	990		20	99	99	198	21
22	Fire Sentinel	2002	844		20	84	84	169	22
23	Tile Repairs	2002	1,303		20	130	130	261	23
24	Plaster Repairs	2002	1,192		20	119	119	209	24
25	Generator Repairs	2002	1,170		20	117	117	215	25
26	Pump And Motor	2002	1,480		20	148	148	222	26
27	Boiler Repairs	2002	1,756		20	146	146	195	27
28	Pump Repairs	2002	1,538		20	154	154	192	28
29	Boiler Repairs	2002	5,015		20	439	439	439	29
30	Elevator Work	2003	4,700		20	235	235	235	30
31	Garage Door	2003	1,955		20	196	196	196	31
32	Flooring	2003	54,803		20	2,055	2,055	2,055	32
33	Handrails	2003	7,291		20	1,094	1,094	1,094	33
34	TOTAL (lines 1 thru 33)		\$ 10,168,624	\$ 301,616		\$ 493,282	\$ 191,666	\$ 5,030,479	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

## XI. OWNERSHIP COSTS (continued)

## B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 10,168,624	\$ 301,616		\$ 493,282	\$ 191,666	\$ 5,030,479	1
2	Lobby Wallcovering	2003	5,219		20	43	43	43	2
3	Lobby Painting	2003	3,102		20	26	26	26	3
4	Hot Water Tank	2003	6,440		20	644	644	644	4
5	Kitchen Door	2003	4,839		20	242	242	242	5
6	Water Heater	2003	2,619		20	131	131	131	6
7	Elevator Car 2	2003	86,889		20	3,620	3,620	3,620	7
8	Elevator Car 1	2003	87,890		20	1,465	1,465	1,465	8
9	Lobby Renovation	2003	214,810		20	16,111	16,111	16,111	9
10	Drain Valve	2003	1,486		20	74	74	74	10
11	Pipe Repairs	2003	1,898		20	87	87	87	11
12	Motor & Pump	2003	1,031		20	43	43	43	12
13	Wall Corner Guards	2003	550		20	18	18	18	13
14	Cubicle Track	2003	582		20	7	7	7	14
15	Mini Blinds	2003	503		20	4	4	4	15
16	Cubicle Curtain	2003	137		20	1	1	1	16
17	Resident Blinds	2003	175		20	1	1	1	17
18	Elevator Generator	2003	4,166		20	174	174	174	18
19									19
20									20
21									21
22									22
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,590,960	\$ 301,616		\$ 515,973	\$ 214,357	\$ 5,053,170	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$ 10,590,960	\$ 301,616		\$ 515,973	\$ 214,357	\$ 5,053,170	1
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4									4
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,590,960	\$ 301,616		\$ 515,973	\$ 214,357	\$ 5,053,170	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	2	3	4	5	6	7	8	9
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1	Totals from Page 12E, Carried Forward		\$ 10,590,960	\$ 301,616		\$ 515,973	\$ 214,357	\$ 5,053,170
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34	TOTAL (lines 1 thru 33)		\$ 10,590,960	\$ 301,616		\$ 515,973	\$ 214,357	\$ 5,053,170

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$ 10,590,960	\$ 301,616		\$ 515,973	\$ 214,357	\$ 5,053,170	1
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,590,960	\$ 301,616		\$ 515,973	\$ 214,357	\$ 5,053,170	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$ 10,590,960	\$ 301,616		\$ 515,973	\$ 214,357	\$ 5,053,170	1
2									2
3									3
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5									5
6									6
7									7
8									8
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10									10
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,590,960	\$ 301,616		\$ 515,973	\$ 214,357	\$ 5,053,170	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)								
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.								
1	2	3	4	5	6	7	8	9
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
1	Totals from Page 12H, Carried Forward		\$ 10,590,960	\$ 301,616		\$ 515,973	\$ 214,357	\$ 5,053,170
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30								
31								
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33								
34	TOTAL (lines 1 thru 33)		\$ 10,590,960	\$ 301,616		\$ 515,973	\$ 214,357	\$ 5,053,170

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$ 10,590,960	\$ 301,616		\$ 515,973	\$ 214,357	\$ 5,053,170	1
2									2
3									3
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31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,590,960	\$ 301,616		\$ 515,973	\$ 214,357	\$ 5,053,170	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12J, Carried Forward		\$ 10,590,960	\$ 301,616		\$ 515,973	\$ 214,357	\$ 5,053,170	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 10,590,960	\$ 301,616		\$ 515,973	\$ 214,357	\$ 5,053,170	34

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**  
**B. Building Depreciation-Including Fixed Equipment.** (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1991	1991	\$ 7,267,981	\$ 230,730		\$ 363,399	\$ 132,669	\$ 4,421,354	4
5											5
6											6
7											7
8											8
9	Improvement Type**										9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-BLDG, Line 70 for total  
SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)
 B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 7,267,981	\$ 230,730		\$ 363,399	\$ 132,669	\$ 4,421,354	70

Facility Name &amp; ID Number Albany Care Inc

# 0037762

Report Period Beginning:

01/01/03

Ending:

12/31/03

**XL OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	SIR Properties		1993	1993	\$ 56,839	\$ 1,805	35	\$ 1,624	\$ (181)	\$ 17,051	4
5	SIR Properties		1993	1193	23,936	760	35	684	(76)	7,181	5
6											6
7											7
8											8
	<b>Improvement Type**</b>										
9	Allocated Albany Care, LLC		1993		58,478	3,452	15	3,456	4	42,942	9
10											10
11	Allocated Preferred Bookkeeping		1997		29,892	669	20	1,495	826	10,177	11
12	Allocated Preferred Bookkeeping		1999		237	-	20	12	(12)	53	12
13	Allocated Preferred Bookkeeping		2000		1,499	-	20	75	75	256	13
14											14
15	Allocated S.I.R. Management		1993		24,412	680	20	1,229	549	13,314	15
16	Allocated S.I.R. Management		1994		76	-	20	8	8	71	16
17	Allocated S.I.R. Management		1995		558	-	20	28	28	235	17
18	Allocated S.I.R. Management		1999		2,656	-	20	133	133	539	18
19	Allocated S.I.R. Management		2000		1,601	-	20	80	80	295	19
20											20
21	Allocated S.I.R. Properties/S.I.R. Management		1993		922	15	20	46	31	484	21
22	Allocated S.I.R. Properties/S.I.R. Management		1994		541	14	20	27	13	257	22
23	Allocated S.I.R. Properties/S.I.R. Management		1997		214	21	20	11	(10)	80	23
24	Allocated S.I.R. Properties/S.I.R. Management		1998		3,442	344	20	172	(172)	946	24
25	Allocated S.I.R. Properties/S.I.R. Management		1999		7,202	721	20	360	(361)	1,620	25
26	Allocated S.I.R. Properties/S.I.R. Management		2002		225	-	20	11	11	17	26
27											27
28	Allocated S.I.R. Properties/Preferred Bookkeeping		1993		388	6	20	19	13	204	28
29	Allocated S.I.R. Properties/Preferred Bookkeeping		1994		228	6	20	11	5	108	29
30	Allocated S.I.R. Properties/Preferred Bookkeeping		1997		90	9	20	5	(4)	34	30
31	Allocated S.I.R. Properties/Preferred Bookkeeping		1998		1,449	145	20	72	(73)	399	31
32	Allocated S.I.R. Properties/Preferred Bookkeeping		1999		3,033	303	20	152	(151)	682	32
33	Allocated S.I.R. Properties/Preferred Bookkeeping		2002		95	-	20	5	5	7	33
34											34
35											35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	3	4	5	6	7	8	9		
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37		\$	\$		\$	\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
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56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)	\$ 218,013	\$ 8,950		\$ 9,715	\$ 741	\$ 96,952		70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 651,166	\$ 90,464	\$ 73,325	\$ (17,139)	10	\$ 433,553	71
72	Current Year Purchases	35,341	5,852	3,075	(2,777)	10	3,075	72
73	Fully Depreciated Assets	690,257				10	690,247	73
74								74
75	TOTALS	\$ 1,376,764	\$ 96,316	\$ 76,400	\$ (19,916)		\$ 1,126,875	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 12,052,281	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 397,932	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 592,373	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 194,441	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,180,045	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease \_\_\_\_\_.

9. Option to Buy: ☐ YES ☐ NO Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 19,654

Description: See Attached Schedule

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY	SIR	\$ 350.00	\$ 4,200	17
18	FACILITY	2000 Ford	517.00	2,335	18
19	FACILITY	1997 Chevy Omni	354.00	4,246	19
20	FACILITY	2000 GMAC	564.00	6,347	20
21	TOTAL		\$ 1,785.00	\$ 17,128	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. \_\_\_\_\_/2004 \$ \_\_\_\_\_

13. \_\_\_\_\_/2005 \$ \_\_\_\_\_

14. \_\_\_\_\_/2006 \$ \_\_\_\_\_

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility		2	3	4
		Drop-outs	Completed	Contract	Total	
1	Community College Tuition	\$	\$	\$	\$	
2	Books and Supplies					
3	Classroom Wages (a)					
4	Clinical Wages (b)					
5	In-House Trainer Wages (c)					
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS	\$	\$	\$	\$	
10	SUM OF line 9, col. 1 and 2 (e)	\$				

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
(c) For in-house training programs only. Do not include fringe benefits.  
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.  
SEE ACCOUNTANTS' COMPILATION REPORT

**XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)**

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist	N/A	hrs	\$		
2	Licensed Speech and Language Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify): See Supplemental										13
14	TOTAL			\$		\$	\$		\$		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 125,189	\$ 127,310	1
2	Cash-Patient Deposits	38,377	38,377	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	1,482,027	1,923,627	3
4	Supply Inventory (priced at )			4
5	Short-Term Investments			5
6	Prepaid Insurance	38,319	38,319	6
7	Other Prepaid Expenses	13,495	13,495	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): <a href="#">See Attached Schedule</a>	159,666	159,666	9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 1,857,073	\$ 2,300,794	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		84,558	13
14	Buildings, at Historical Cost		7,267,981	14
15	Leasehold Improvements, at Historical Cost	2,274,830	2,333,308	15
16	Equipment, at Historical Cost	1,901,056	1,901,056	16
17	Accumulated Depreciation (book methods)	(1,601,195)	(4,441,735)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): <a href="#">See Attached Schedule</a>	32,986	109,334	23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 2,607,677	\$ 7,254,502	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 4,464,750	\$ 9,555,296	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 146,937	\$ 146,937	26
27	Officer's Accounts Payable	12,181	12,181	27
28	Accounts Payable-Patient Deposits	48,365	48,365	28
29	Short-Term Notes Payable	850,000	850,000	29
30	Accrued Salaries Payable	349,585	349,585	30
31	Accrued Taxes Payable (excluding real estate taxes)	51,036	492,636	31
32	Accrued Real Estate Taxes(Sch.IX-B)	441,600	441,600	32
33	Accrued Interest Payable	850	58,339	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	40,500	40,500	35
	<b>Other Current Liabilities(specify):</b>			
36	<a href="#">See Attached Schedule</a>	102,571	102,571	36
37				37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 2,043,625	\$ 2,542,714	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	819,469	819,469	39
40	Mortgage Payable		11,098,207	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	<a href="#">See Attached Schedule</a>			43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$ 819,469	\$ 11,917,676	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 2,863,094	\$ 14,460,390	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 1,601,656	\$ (4,905,094)	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 4,464,750	\$ 9,555,296	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1 Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	<b>\$ 1,522,240</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	<b>\$ 1,522,240</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>1,330,416</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>(1,251,000)</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ 79,416</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 1,601,656</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

	Revenue	Amount	
	<b>A. Inpatient Care</b>		
1	Gross Revenue -- All Levels of Care	\$ 11,806,653	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 11,806,653	3
	<b>B. Ancillary Revenue</b>		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
	<b>C. Other Operating Revenue</b>		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$	23
	<b>D. Non-Operating Revenue</b>		
24	Contributions		24
25	Interest and Other Investment Income***	1,186	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,186	26
	<b>E. Other Revenue (specify):****</b>		
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See Supplemental Schedule	651	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 651	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 11,808,490	30

	Expenses	Amount	
	<b>A. Operating Expenses</b>		
31	General Services	1,738,863	31
32	Health Care	3,380,223	32
33	General Administration	2,637,539	33
	<b>B. Capital Expense</b>		
34	Ownership	2,493,142	34
	<b>C. Ancillary Expense</b>		
35	Special Cost Centers		35
36	Provider Participation Fee	228,307	36
	<b>D. Other Expenses (specify):</b>		
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 10,478,074	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	1,330,416	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ 1,330,416	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? Cash Basis If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name &amp; ID Number Albany Care Inc

# 0037762

Report Period Beginning: 01/01/03

Ending:

12/31/03

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,854	2,081	\$ 102,773	\$ 49.39	1
2	Assistant Director of Nursing	3,800	4,084	86,051	21.07	2
3	Registered Nurses	3,134	3,337	79,715	23.89	3
4	Licensed Practical Nurses	33,278	36,079	754,112	20.90	4
5	Nurse Aides & Orderlies	108,655	115,462	1,048,124	9.08	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,655	3,978	20,117	5.06	8
9	Activity Director	2,753	2,970	44,573	15.01	9
10	Activity Assistants	34,924	38,111	328,406	8.62	10
11	Social Service Workers	30,553	33,560	481,100	14.34	11
12	Dietician					12
13	Food Service Supervisor	1,813	2,086	41,649	19.97	13
14	Head Cook	5,228	5,810	51,438	8.85	14
15	Cook Helpers/Assistants	20,535	22,069	179,044	8.11	15
16	Dishwashers					16
17	Maintenance Workers	5,607	5,991	73,087	12.20	17
18	Housekeepers	27,685	30,186	242,241	8.02	18
19	Laundry					19
20	Administrator	1,799	2,086	114,321	54.80	20
21	Assistant Administrator	1,719	1,859	37,942	20.41	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	26,189	28,546	285,875	10.01	24
25	Vocational Instruction	7,349	7,349			25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	6,956	7,768	128,054	16.48	31
32	Other Health Care(specify)					32
33	Other(specify) See Supplemental					33
34	TOTAL (lines 1 - 33)	327,486	353,412	\$ 4,098,622 *	\$ 11.60	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 64,140	01-03	35
36	Medical Director	Monthly	3,600	09-03	36
37	Medical Records Consultant	96	4,128	10-03	37
38	Nurse Consultant	Monthly	82,572	10-03	38
39	Pharmacist Consultant	Monthly	3,979	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	Monthly			41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	3	117	10a-03	43
44	Activity Consultant				44
45	Social Service Consultant	15	649	12-03	45
46	Other(specify)				46
47	Specialized Rehab	5,822	37,032	10a-03	47
48	Psychiatric Director	Monthly	4,800	10-03	48
49	TOTAL (lines 35 - 48)	5,936	\$ 201,017		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	2,862	\$ 111,599	10-03	50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)	2,862	\$ 111,599		53

SEE ACCOUNTANTS' COMPILATION REPORT

## **XIX. SUPPORT SCHEDULES**

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%	Amount	Description	Amount	Description	Amount		
Dennis Tossi	Administrator	3.12	\$ 113,889	Workers' Compensation Insurance	\$ 40,753	IDPH License Fee	\$		
Elizabeth Salazar	Asst Admin	0	22,901	Unemployment Compensation Insurance	22,913	Advertising: Employee Recruitment	14,930		
1/1/03-7/19/03				FICA Taxes	305,797	Health Care Worker Background Check (Indicate # of checks performed 41 )	287		
Dan Allegretti	Asst Admin	0	15,473	Employee Health Insurance	198,387	Advertising	14,018		
8/10/03-12/31/03				Employee Meals	14,454	Yellow Page Ads	432		
				Illinois Municipal Retirement Fund (IMRF)*		Dues/Subscriptions	15,546		
				Employee Benefits	15,939	Filing Fees (Albany Care LLC)	25		
						Licenses/Fees	26,927		
						See Supplemental Schedule	468		
						Less: Public Relations Expense (			
						Non-allowable advertising	(14,018)		
						Yellow page advertising	(432)		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 152,263			TOTAL (agree to Sch. V, line 20, col. 8)	\$ 58,182		
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees				G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount	
Dir of Admin Services-S.I.R. Management			\$ 52,548			\$	Out-of-State Travel	\$	
Owners Council Dues			15,600						
See Supplemental Schedule			649,510				In-State Travel		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 717,658						
C. Professional Services									
Vendor/Payee	Type		Amount						
See Attached Schedule	Legal Fees		\$ 28,776						
FR&R	Accounting		12,615						
Personnel Planners	Unemployment Tax Cons		1,571						
ICS Solutions	Internet Services		1,215						
LTC Solutions	Computer Services		1,320						
Preferred Bookkeeping	Bookkeeping		130,104						
Preferred Bookkeeping	Computer Services		10,008						
S.I.R. Management	Legal Fees		10,008				Seminar Expense	7,777	
S.I.R. Management	Professional Fees		33,780				Alloc from Preferred	256	
Preferred Bookkeeping	Accounting		28,500				Alloc from S.I.R. Mgt	685	
							Entertainment Expense (		
							(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 257,897	TOTAL		\$	TOTAL	\$ 8,718	

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

**\*\*See instructions.**

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Albany Care Inc

STATE OF ILLINOIS

# 0037762

Report Period Beginning:

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. ICLTC - \$19,253
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 175 Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. N/A
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 228,307  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? no For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 14,454 Has any meal income been offset against related costs? No Indicate the amount. \$ N/A
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ N/A
- c. What percent of all travel expense relates to transportation of nurses and patients? 100% in 14
- d. Have vehicle usage logs been maintained? Yes
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? No
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
- g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A**
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N/A If no, please explain. N/A
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.